DIVISION OF ADULT INSTITUTIONS **POLICY AND PROCEDURES**	**DAI Policy #:** 500.60.02	**Page** 1 of 10
	Original Effective Date: 10/01/04	**New Effective Date:** 04/08/19
	Supersedes: 500.60.02	**Dated:** 03/01/18
	Administrator's Approval: Makda Fessahaye, Administrator	
	Required Posting or Restricted: [X] **Inmate** [X] **All Staff** [ ] **Restricted**	
Chapter: 500 Health Services		
Subject: Tuberculosis Control Program – Inmate		

POLICY

Division of Adult Institution facilities shall have Tuberculosis (TB) prevention and control plans in compliance with Centers for Disease Control (CDC) and Department of Health Services (DHS) recommendations. This policy addresses screening, testing, risk assessment, treatment and tracking of latent tuberculosis infection (LTBI) and TB disease.

REFERENCES

Wisconsin Administrative Code Ch. DOC 311 – Sections DOC 311.10 and 311.12 - Observation
Wisconsin Administrative Code Ch. DOC 375 – Observation Status in Type 1 Secured Correctional Facilities
Wisconsin Administrative Code DHS 145
Executive Directive 35 – Confidentiality of Offender Health Information
DAI Policy 500.00.05 – Medical Observation and Monitoring
DAI Policy 500.60.01 – Infection Prevention and Control Program
DAI Policy 500.60.10 – External Reporting of Communicable Diseases
DAI Policy 500.60.13 – Airborne/Droplet Infections
Standards for Health Services in Prisons, National Commission on Correctional Health Care, 2018 P-B-02 Infectious Disease Prevention and Control, and 2018 P-E-02 Receiving Screening
Core Curriculum on Tuberculosis, 6th Edition, 2013; American Journal of Nursing, August 2017 Vol 117, No. 8-"Tuberculosis: A New Screening Recommendation and an Expanded Approach to Elimination in the United States"
Centers for Disease Control and Prevention – Recommendations for Tuberculosis Testing. http://www.cdc.gov/tb
MMWR-July 7, 2006/55 (RR09); 1-44 Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC
OSHA's Respiratory Standard 29 CFR 1910.134
Wisconsin Tuberculosis Program, Wisconsin Department of Health Services http://dhs.wisconsin.gov/tb/index.htm

DEFINITIONS, ACRONYMS AND FORMS

Advanced Care Provider (ACP) – A provider with prescriptive authority.

Airborne Infection Isolation Room (AIIR) – A single patient room with negative pressure ventilation isolation room with characteristics appropriate for the purposes of isolating patients who have suspected/confirmed airborne infection.

Airborne Precautions – Cautionary measures intended to decrease the likelihood of transmission of organisms that can be carried in particles of less than five micrometers in dust particles or droplet nuclei.

ALT – Alanine Aminotransferase

AST – Aspartate Aminotransferase

BCG – Bacillus Calmette-Guerin

BHS – Bureau of Health Services

CBC – Complete blood count

CDC – Centers for Disease Control

DAI – Division of Adult Institutions

DHS-TB Program – Department of health Services Tuberculosis Program

Directly Observed Therapy (DOT) - visual monitoring by a health care worker of patients' ingestion of medications, to ensure compliance in difficult or long-term regimens, such as in oral treatment for tuberculosis.

DOC- 2077 - Health Transfer Summary

DOC-3003 – Health Summary

DOC-3032 – INH and RPT Treatment Flow Sheet

DOC-3220 – Refusal of Recommended Health Care

DOC 3504A- Infection Control Notice

DOC-3504 – Infection Control: Patient and Employee Precautions

DPH-F-44000 – Wisconsin Anti-tuberculosis Therapy Program Initial Request for Medication.

DPH-F-02265 – LTBI Confidential Case Report (locate form at https://www.dhs.wisconsin.gov/tb/index.htm under the forms tab)

DPH-F-44125 – LTBI Follow-up Form (locate form at https://www.dhs.wisconsin.gov/tb/index.htm under the forms tab.)

HIV – Human Immunodeficiency Virus

HSU – Health Service Unit

IGRA - Interferon-Gamma Release Assay is blood test that can aid in diagnosing Mycobacterium tuberculosis infection.

Isoniazid (INH) - Medication used in conjunction with RPT to treat LBTI.

Latent Tuberculosis Infection (LTBI) - A condition in which relatively small number of living tubercle bacilli (Mycobacterium tuberculosis) are present in the body but are not multiplying or causing clinically active disease and are not infectious.

LFT – Liver function tests

Medical Observation (DAI) – An involuntary or voluntary status used for the temporary confinement of an inmate as allowed in Wisconsin Administrative Code s. DOC 311.10. The inmate shall be confined alone in a well-ventilated, sanitary, secure cell equipped with an observation port. Transfers to another facility while in medical observation shall not occur unless it is for medical reasons.

MMWR – Morbidity and Mortality Weekly Report

Mycobacterium Tuberculosis – the bacteria that causes Tuberculosis.

NIOSH – National Institute for Occupational Safety and Health

OSHA – Occupational Safety and Health Administration

POC-0040A – Infection Control Personal Protective Equipment (PPE)

PAPR-Powered Air Purifying Respirator

QuantiFERON®-TB Gold a blood test for Tuberculosis.

Rifapentine (RPT) – Medication used in conjunction with INH to treat LTBI.

SharePoint- Database containing monthly TB statistics.

Tuberculosis Disease – a clinically active disease state that is caused by organisms of the Mycobacterium tuberculosis complex. Persons who have TB disease usually have symptoms, which differ according to the site of disease. Commonly referred to as active TB. People with active disease are infectious to others.

Tuberculosis Testing- Two types of tests that can detect M. Tuberculosis in the body: the tuberculin skin test (TST) and IGRA blood test. A positive TST or IGRA test only indicates infection with M. tuberculosis; further tests are required to rule out active or latent tuberculosis disease.

USPSTF –United States Preventative Services Task Force

PROCEDURES

I. Screening/ Risk Assessment

A. General

1. A TB screening shall be completed to screen all patients for risk factors and signs and symptoms of TB. A screening consists of an interview to identify signs and symptoms, and to determine risk for TB disease.
2. Health care staff shall conduct the screening. If any positive symptoms are identified on the screening, a RN shall complete and document a physical assessment.
3. IGRA testing with Quantiferon Gold (QFT-G) is the method DOC will utilize to determine whether a person is infected with mycobacterium tuberculosis.
4. Pregnancy, lactation or previous vaccination with BCG vaccine are not contraindications for IGRA testing.

B. Interpretation of results shall be completed by an ACP

1. A patient with a positive IGRA shall have a TB screen completed by a RN. Positive Quantiferon results and confirmed cases of LTBI shall be reportable to the WI TB Program.
2. Any patient with risk factors and/or with signs or symptoms of TB on screening and shall be isolated and referred immediately to an ACP.
3. A chest x-ray shall be done immediately for the patient who has signs/symptoms or significant risk factors and within one week for a positive IGRA without significant risk factors and no signs or symptoms.

II. TESTING: IGRA-QuantiFERON TB – Gold

A. All new intakes/admissions shall be tested with IGRA to establish baseline. IGRA testing requires an ACP order.

B. Intake/Admission IGRA testing shall not be completed under the following:

1. If verified TST was completed within the previous 6 months.
2. If past positive TST and completed treatment.
3. If past positive IGRA.

C. All IGRA test results shall be reviewed by the ACP.

D. IGRA testing shall be used in conjunction with risk assessment, radiography and other diagnostic evaluations since a positive IGRA cannot distinguish between LTBI and active TB disease. Interpretation of IGRA:

1. A positive IGRA test indicates there has been an immune response indicating previous exposure to TB bacteria.
2. A positive result does not exclude or differentiate between LTBI or active TB disease.
3. A negative result does not necessarily mean a patient does not have LTBI or TB disease.
4. A negative IGRA test indicates there has not been an immune response to a previous TB exposure, or no previous TB exposure.
5. An indeterminate test indicates the results are unclear due to possible testing error, or the results are not conclusive and shall be referred to ACP for further evaluation.

III. Chest X-Ray

A. Chest x-rays shall not be used in place of an IGRA test or screening for signs/symptoms.

B. The ACP shall determine if Chest x-rays shall be completed for patients with positive IGRA and/or signs and symptoms or risk factors for TB.

C. The hospital/diagnostic service shall be notified of a positive pregnancy so proper shielding can be used during chest x-ray.

IV. Suspected Active Disease

A. If at any time a patient is suspected of having active disease, airborne precautions shall immediately be initiated as outlined in DAI Policies 500.60.01 and 500.60.13.

B. The patient shall be placed in medical observation by an ACP pursuant to DAI Policy 500.00.05.

C. The patient shall be housed in an AIIR located on grounds or offsite as predetermined by the facility's procedure DAI Policy 500.60.13.

D. Staff shall utilize PPE as appropriate, including N95 or PAPR. Refer to POC-0040A.

E. A surgical mask shall be worn by the patient when they are outside of the AIIR.

F. Facilities are required to have procedures to FB control detailing N95 NIOSH respirators training and fit testing.

G. Staff shall wear appropriate respiratory protection (N95 or PAPR) when transporting patients offsite.

H. Alternate transportation providers shall be notified of the patient's status requiring airborne precautions.

I. An ACP in consultation with the DHS TB Coordinator shall determine when a patient may be released from respiratory isolation.

V. Sputum Specimens

A. Sputum specimens are indicated in persons suspected of having active TB disease due to the following:
   1. Chest x-ray consistent with pulmonary TB disease, especially if respiratory symptoms suggest disease.
   2. Persons with chest x-ray findings suggestive of previous, healed TB disease.
   3. HIV infected persons with pulmonary symptoms.
   4. Persons suspected of having pulmonary TB disease for which bronchoscopy is planned.

B. Contact the DHS TB Program for instructions on collecting the sputum and isolation and treatment needs of the patient while you are waiting for results.

C. Any patient is considered potentially infectious for TB disease if sputum samples are being collected.

D. Sputum samples shall be collected in an AIIR.

VI. Refusals

A. Patients who refuse an IGRA testing on Intake shall be interviewed for signs and symptoms of active TB.

B. An ACP may place a patient who refuses screening or testing in medical observation. See DAI Policy 500.00.05.

C. Patient refusal of testing shall result in counseling the patient regarding the refusal and informing the patient of potential consequences and risks to others.

D. Refusal and reason for refusal shall be documented on the DOC-3220 and also noted on the DOC-3286.

E. The ACP shall be notified of all refusals.

F. If at any time the health care staff becomes suspicious of active TB disease, the patient shall be isolated and an ACP shall be consulted immediately.

G. The patient shall remain in medical observation until one of the following occurs:
   1. An ACP determines they are not at risk for transmitting active disease to others.
   2. The patient complies with screening or IGRA test.

H. Patients shall not be transferred to another facility while in medical observation status, unless a higher level of care is necessary.

VII. Reporting

A. HSU staff shall communicate precautions by completing a DOC-3504A – Infection Control Notice and 3504 - Infection Control: Patient and Employee Precautions and immediately alert the appropriate staff of the precautions.

B. Actual or suspected active disease requires immediate reporting via telephone to the local public health agency.

C. LTBI is a Category II reportable condition. The DPH-F-02265 LTBI Confidential Case Report shall be completed and sent to the Wisconsin TB Program within 72 hours @ dhswitbprogram@wi.gov.

D. When a patient completes a recommended course of LBTI therapy or discontinues treatment, DPH-F-44125 LTBI Follow-up Form shall be completed and sent to the Wisconsin TB Program @ dhswitbprogram@wi.gov.

E. The HSM/designee shall contact the Warden/designee, facility infection control designee, BHS Director, Director of Nursing, Infection Control Committee Coordinator and the Nursing Coordinator responsible for the facility.

VIII. Medical and Case Management – Latent Tuberculosis Infection

A. The ACP shall evaluate all patients with LTBI for potential chemoprophylaxis with INH and RPT.

B. First-line treatment for newly diagnosed cases of LBTI shall include a combination regimen of INH plus RPT administered together weekly for 12 weeks as DOT. Standard dosage as follows: Dosage as follows:
   1. INH: 15 mg/kg rounded up to the nearest 50 or 100 mg (900 mg maximum).
   2. RPT: >=50 kg (900 mg. maximum); lower doses for weights under 50 kg.

C. The first line treatment as described in VIII. B. above is not recommended for patients with:
   1. HIV/AIDS who are being treated with protease inhibitors and most non-nucleoside reverse transcriptase inhibitors.
   2. People presumed to be infected with INH or RIF-resistant M. tuberculosis.
   3. Pregnant women or women expecting to become pregnant within the 12 week regimen.

D. Patients with a history of positive IGRA or TST results who have previously completed treatment for LTBI do not need to be treated again unless concern exists that reinfection has occurred.

E. Patients diagnosed with LTBI or active TB shall be scheduled for review for signs/symptoms of TB following treatment.

F. Baseline and routine laboratory monitoring during treatment of LTBI are indicated only when there is a history of liver disease, HIV infection, pregnancy (or within three months post-delivery). Baseline hepatic measurements include:
   1. CBC.
   2. AST.
   3. ALT.
   4. Bilirubin.

G. LFTs are recommended every two to four weeks while on therapy in patients with abnormal liver tests and/or liver disease.

H. Patients on INH and RPT therapy shall be assessed weekly by a nurse during treatment.

I. Assessments shall be documented on the DOC-3032 – INH and RPT Treatment Flow Sheet until treatment is completed.

J. Prescribed treatment with INH and RPT shall be administered by licensed health staff using DOT weekly for 12 weeks and shall be documented on the DOC-3026 – Medication/Treatment Record.

K. Patients shall not be transferred to the Center System during the 12 week treatment regime requiring DOT by licensed staff.

IX. Contact Investigation

A. Facilities shall work with BHS, DHS DPH TB Program, facility infection control designee, Local Public Health Agency and the assigned employee health nurse, to determine if and how to proceed with contact investigation.

B. The investigation shall focus on identifying the contacts of highest risk for transmission, screening and determination of appropriate treatment if needed.

C. Guidelines for contact investigation methods are identified in the Core Curriculum on Tuberculosis, 6th Edition, 2013; CDC TB home page.

X. Continuity of Care Issues

A. Discharge planning shall be done to ensure that patients who are receiving LBTI or active TB treatment are able to obtain medications and be followed in the community for compliance.

B. Patients who are receiving treatment for LTBI or active TB shall be referred to the county public health department where they will reside upon discharge.

C. The DPH-F-44000 – Wisconsin Antituberculosis Therapy Program Initial Request for Medication shall be completed and forwarded to the LPHA to obtain prescriptions and alert the LPHA to follow the offender for compliance. If the patient's community address is unknown, enter the name and telephone number of the DCC Probation and Parole agent.

D. HSU staff shall no patients of the need for continued care prior to discharge. The need for continued treatment shall be documented on the DOC-3003.

XI. Prevention and Surveillance

A. Each facility shall implement an effective TB prevention and control program as outlined in OSHA's Respiratory Standard 29 CFR 1910.134.

B. Surveillance shall be accomplished by monitoring laboratory data, SharePoint data entry and available reporting tools.

C. A risk assessment by the infection control committee shall be performed annually and conducted in collaboration with the Wisconsin Department of Health Services TB Program. Minimal TB risk is determined based on four criteria:
   1. No cases of infectious TB have occurred in a facility in the last year.
   2. The facility does not house substantial numbers of patients with risk factors.
   3. The facility does not house substantial numbers of new immigrants (arriving within the previous 5 years) from areas of the world with high TB rates.
   4. Employees of the facility are not otherwise at risk for TB.

Bureau of Health Services: _____Date Signed: _____
James Greer, Director

_____Date Signed: _____
Paul Bekx, MD, Medical Director

_____Date Signed: _____
Mary Muse, Nursing Director

Administrator's Approval: _____Date Signed: _____
Makda Fessahaye, Administrator

.DIVISION OF ADULT INSTITUTIONS FACILITY IMPLEMENTATION PROCEDURES

Facility: Name		
Original Effective Date:	**DAI Policy Number:** 500.60.02	**Page** 10 of 10
New Effective Date:	**Supersedes:** 500.60.02	**Dated:**
Chapter: 500 Health Services		
Subject: Tuberculosis Control Program		
Will Implement ☐ As written ☐ With below procedures for facility implementation		
Warden's/Center Superintendent's Approval:		

REFERENCES

DEFINITIONS, ACRONYMS AND FORMS

FACILITY PROCEDURE

I.

A.

B.

1.

2.

a.

b.

c.

3.

C.

II.

III.

RESPONSIBILITY

I. Staff

II. Inmate

III. Other